STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155715	A. BUILDING 00 B. WING	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

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F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: June 18, 19, 20 and 21, 2012 Facility number: 000347 Provider number: 155715 AIM number: 100275440 Survey team: Marla Potts, RN, TC Susan Worsham, RN Sharon Whiteman, RN Census bed type: SNF/NF: 105 Residential 34 Total: 139 Census payor type: Medicare: 17 Medicaid: 54 Other: 68 Total: 139 Sample: 21 Residential Sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/22/12 Cathy Emswiller RN			

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F0157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview, and record review the facility failed to ensure nursing staff promptly notified the physician of Resident #34's pressure ulcer	F0157	F 157 Notify of Changes It is the policy of this facility to immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or	07/04/2012

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	worsening from a stage 1 pressure sore on 5/22/12, which progressed to a stage 2 on 5/31/12 and to a stage 3 on 6/20/12, for 1 of 21 residents reviewed for notification in the sample of 21. Findings Include: On 06/18/12 at 10:00 a.m. Resident #34 was observed to have an open are on her coccyx. Review of Resident #34's clinical record on 06/18/12 at 4:15 p.m. indicated the following: A physician's re-write, signed 5/26/12, included an order which was started 5/25/2012, for "Facility Barrier Cream - apply to coccyx, buttocks, & peri area three times a day for maintenance." A nurse's note dated 05/22/12 at 9:00 p.m. indicated, "Assessed pressure 1 area to coccyx. Area is chronic condition & will monitor weekly for area to be continue improvement (sic). Area is opened this week. Measuring 0.4 x 0.4 x (less than sign) 0.1. Continue A&D ointment q shift....This nurse's note was signed by LPN #2. A weekly pressure ulcer healing record dated 05/22/12 indicated Resident #34		an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.Corrective Action For The Resident Affected:The physician was notified of the decline in the resident's pressure area and orders were received and implemented for the treatment of her pressure area. The resident had been declining for several weeks and her decline ended in her passing away the day after the close of our survey. Other Residents Having The Potential To Be Affected:All residents having pressure sores have the potential to be affected. The charts of all residents with pressure sores were audited to assure that current documentation is accurate and that the wound treatment is appropriate for the stage of the wound. (Attachment titled Weekly Wound Audit). The charts were also audited to ensure that the appropriate communication and notification of the physician was occurring. All of the other resident's care and notification was found to be appropriate.New wound process checklists with step-by-step	

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	had a 0.4 cm x 0.4 cm stage 1 pressure area on her coccyx.... "Area opened up. Cont [Continue] A&D ointment (preventative ointment frequently used for diaper rash)." A nurse's note, dated 05/24/12 at 8:30 p.m., indicated a physician's response to Resident #34's blood sugars. The nurse's note lacked documentation supporting the physician was notified of Resident #34 having a new open area. A Weekly Pressure Ulcer Healing Record, dated 05/31/12, indicated, "Area open - wound 1 x 1 cm [centimeter] 0.2 cm deep, stage 2...covered wound with moist collagen & Allevyn dsy [dressing]." A nurse's note dated 05/31/12 at 10:30 p.m. indicated, "When checking Res (Resident #34's) coccyx, found that area has re-opened approx [approximately] 1.0 x 1.0 cm, round in appearance, pink/dusky in color. 0 [No] drainage. Approx 0.2 cm deep. Cleansed area c N.S. [normal saline]. Applied moistened collagen (wound treatment) to area, then applied Allevyn (wound treatment) Thin to area. Left msg in care track for wound care nurse (LPN #2)." During interview, on 6/21/12 at 8:30 A.M., with LPN #3, she indicated she had applied the collagen and dressing because the area was open		instructions on how to handle new pressure areas were developed. (Attachment titled Wound Process Checklist). SBAR forms for pressure ulcer status notification was initiated for nursing staff to use in notifying the physician of significant changes in wound status, to request treatment changes, and to suggest possible appropriate wound treatments. (Attachment titled SBAR; Pressure Ulcer Status Notification). A reference sheet was developed for making treatment recommendations to the physician based upon the wound stage and this is included in the new wound process packet. (Attachment titled Treatment Recommendations Reference Sheet). The daily documentation of pressure areas was revised. (Attachment titled Pressure Ulcer Daily Documentation). New forms were placed in the nurses notes and pink pressure ulcer alert tabs were placed on the spine of the charts of residents with pressure areas. (Attachment titled Pressure Alert). The Weekly Pressure Ulcer Healing Record forms were revised to make them easier for all nursing staff to complete accurately. (Attachment titled Weekly Pressure Ulcer Record). Nursing staff education was completed on June 26th and 28th to provide training related to pressure ulcers with a focus on staging, treatment	

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	and had left a note in caretracker for the wound nurse. She indicated she thought the area needed a dressing as it was open. LPN #3 indicated she had not notified a physician. The next entry on the Weekly Pressure Ulcer Healing Record, dated 06/05/12, indicated the area was "improved" and A&D ointment was used. Wound measurements for this date were 0.8 cm x 0.7 cm, a stage 2 pressure ulcer. A Weekly Pressure Ulcer Healing Record, dated 06/12/12 indicated Resident #34's coccyx area wound measured 0.2 x 0.6 cm. and A&D ointment was the treatment at this time, a stage 2 pressure ulcer. A nurses notes entry, dated 6/14/12 8 p.m., indicated " assessed pressure I area to coccyx. Measures .2 by .2 by less than .1. A & D continues every shift...routinely dependant on staff for all care..." A physician's telephone order, dated 06/18/12, indicated, "Pressure Area to coccyx: Cleanse c NS [Normal Saline] apply Collagen piece, foam & cover q day & prn x 7 days & re-eval." The facility lacked evidence of the physician having been notified of the area		recommendations and proper physician notification. (Attachment titled Pressure Ulcers Staff Education POC 2012). The new forms and process for handling new and worsened pressure areas was discussed.Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur:Pressure ulcer training will occur during new employee orientation that will focus on our policy with emphasis on staging and MD notification for changes in wound status. (Attachment titled Pressure Ulcers Education NEO). A wound process checklist was developed that will guide the staff in their care and will be turned into the Director of Nursing or her designee for review. (Attachment titled Wound Process Checklist). These will then be forwarded to the wound care nurse. The Director of Nursing or her designee will visualize each pressure area in the building weekly and review documentation in the clinical record for accuracy and appropriate physician notification. The Director of Nursing will keep an audit tool to track her weekly wound checks.(Attachment titled Weekly Wound Audit).Monitoring of Corrective Action:Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and	

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	opening from a stage 1 pressure area on 5/22, to a stage 2 pressure area on 5/31/12, and remaining a stage 2 pressure area, until 6/18/12. On 06/20/12 at 1:35 p.m. LPN #2 was observed to measure the area on Resident #34's coccyx. The area measured 1.5 length x 1.1 width x 1.5 depth. The area was observed to have yellow slough in center with pink surrounding the slough. LPN #2 indicated the area was a stage III area. The clinical record was reviewed on 6/21/12 at 9:00 A.M. and documentation was lacking of the facility having made the physician aware of the area worsening to a stage 3 pressure ulcer. The policy and procedure, obtained from the Director of Nursing, on 6/21/12 at 9:30 A.M., no date, indicated, "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On call Physician when there has been: ...a significant change in the residents physical/emotional/mental condition...a need to alter the residents medical treatment significantly...except in medical emergencies notification will be made within twenty four hours of a change occurring in the residents...status.		documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop. Pressure areas will always be an area of concern and will continue to remain on the agenda monthly for the Quality Assurance Committee to review and discuss.	

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	3.1-40(a)(2)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review the facility failed to ensure a resident did not develop a stage 3 pressure sore while residing within the facility, in that Resident #34 was observed to have a stage 1 pressure sore on 5/22/12 which progressed to a stage 2 on 5/31/12 and to a stage 3 on 6/20/12 without physician notification of the area worsening, for 1 of 5 residents reviewed for pressure ulcers in the sample of 21. Findings Include: On 06/18/12 at 10:00 a.m. CNA #1 and CNA #2 were observed to provide incontinence care for Resident #34. The resident was observed to have been incontinent of both stool and bladder. While CNA #1 was cleansing Resident #34's bottom of stool and wiping front to back, an open area was observed in Resident #34's inner mid buttocks.	F0314	F 314 Treatment/Services To Prevent/Heal Pressure SoresIt is the policy of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.Corrective Action For The Resident Affected:The physician was notified of the decline in the resident's pressure area and orders were received and implemented for the treatment of her pressure area. The resident had been declining for several weeks and her decline ended in her passing away the day after the close of our survey. Other Residents Having The Potential To Be Affected:All residents having pressure sores have the potential to be affected. The charts of all residents with	07/04/2012

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	Neither of the CNA's commented on the open area. On 06/19/12 at 10:45 a.m. LPN #1 and RN #1 were observed to provide incontinence care for Resident #34. The resident was observed to have been incontinent of stool and urine. While providing incontinence care, an open area was observed in the resident's mid inner buttocks. LPN #1 indicated she thought a dressing had been placed on the area last evening shift and it had probably fallen off during care and the CNA's had forgotten to tell the nurse. LPN #1 was observed to cleanse the open area with normal saline and applied a piece of collagen which had been moistened with normal saline over the resident's open area, covered the area with a foam dressing, and secured the dressing with cover-roll. Interview of LPN #1 on 06/19/12 at 10:45 a.m. indicated she needed to instruct the CNA's via the Kiosk (computer charting mechanism) to notify nursing when Resident #34's dressing came off. Review of Resident #34's clinical record on 06/18/12 at 4:15 p.m. indicated the following: Resident #34 had diagnoses which		pressure sores were audited to assure that current documentation is accurate and that the wound treatment is appropriate for the stage of the wound. (Attachment titled Weekly Wound Audit). The charts were also audited to ensure that the appropriate communication and notification of the physician was occurring. All of the other resident's care and notification was found to be appropriate.New wound process checklists with step-by-step instructions on how to handle new pressure areas were developed. (Attachment titled Wound Process Checklist). SBAR forms for pressure ulcer status notification was initiated for nursing staff to use in notifying the physician of significant changes in wound status, to request treatment changes, and to suggest possible appropriate wound treatments. (Attachment titled SBAR; Pressure Ulcer Status Notification). A reference sheet was developed for making treatment recommendations to the physician based upon the wound stage and this is included in the new wound process packet. (Attachment titled Treatment Recommendations Reference Sheet). The daily documentation of pressure areas was revised. (Attachment titled Pressure Ulcer Daily Documentation). New forms were placed in the nurses notes	

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	included, but were not limited to, Diabetes, and Multi-Infarct Dementia. An annual MDS [minimum data set] assessment, dated 03/10/12, indicated Resident #34's cognitive status was severely impaired, the resident required extensive assistance of staff for transfers, bathing and hygiene, and bed mobility. The MDS assessment indicated Resident #34 required extensive assistance of staff for bed mobility, was at risk for skin breakdown and had a stage 1 pressure ulcer during the time of the MDS assessment. A physician's fax order, dated 03/08/12, indicated, "...New open area on bony prominence 1.6 x [by] 0.5 x [less than emblem] 0.1...." The fax order indicated the open area was to have a daily and as needed wound treatment of - cleansing the wound with normal saline, and applying antibiotic ointment followed by Collagen and Allevyn dressing (wound treatment) A physician's re-write, signed 5/26/12, included an order which was started 5/25/2012, for "Facility Barrier Cream - apply to coccyx, buttocks, & peri area three times a day for maintenance." Copies of Treatment Sheets were		and pink pressure ulcer alert tabs were placed on the spine of the charts of residents with pressure areas. (Attachment titled Pressure Alert). The Weekly Pressure Ulcer Healing Record forms were revised to make them easier for all nursing staff to complete accurately. (Attachment titled Weekly Pressure Ulcer Record). Nursing staff education was completed on June 26th and 28th to provide training related to pressure ulcers with a focus on staging, treatment recommendations and proper physician notification. (Attachment titled Pressure Ulcers Staff Education POC 2012). The new forms and process for handling new and worsened pressure areas was discussed.Systemic Changes And Steps To Ensure That The Deficient Practice Does Not Recur:Pressure ulcer training will occur during new employee orientation that will focus on our policy with emphasis on staging and MD notification for changes in wound status. (Attachment titled Pressure Ulcers Staff Education NEO). A wound process checklist was developed that will guide the staff in their care and will be turned into the Director of Nursing or her designee for review. (Attachment titled Wound Process Checklist). These will then be forwarded to the wound care nurse. The Director of Nursing or her	

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	provided by LPN #1 on 06/19/12 at 11:35 a.m. The Treatment Sheets included the months of May and June 2012. Both the May and June treatment sheets had an order which was dated, 05/25/10, for "Facility Barrier Cream - apply to coccyx, buttocks, & peri area three times a day for maintenance. A "Daily Monitoring For Pressure Ulcers" sheet, dated April, 2012, indicated a coccyx area pressure sore was healed on 04/11/12. A nurses's note dated 04/25/12 at 2:00 p.m. indicated, "MD responded back to area reported on coccyx. N.O. may have wound care nurse eval [evaluate] and tx [treat] area on coccyx." A nurse's note dated 04/25/12 at 8:00 p.m. indicated, "Looked at area on coccyx. Area continues to have opened up & caused reddened area. Area Pressure I measures 0.3 x 0.3 x (less than sign) 0.1. Cont A&D ointment q shift. Relies on staff for care. Incont of B&B....Will continue to monitor...." This nurse's note was signed by LPN #2. Interview of LPN #2 on 06/19/12 at 2:00 p.m. indicated LPN #2 was the wound nurse and LPN #2 indicated the doctor usually just wanted him (LPN #2) to use		designee will visualize each pressure area in the building weekly and review documentation in the clinical record for accuracy and appropriate physician notification. The Director of Nursing will keep an audit tool to track her weekly wound checks. (Attachment titled Weekly Wound Audit).Monitoring of Corrective Action:Audit results will be reviewed by the Quality Assurance Committee monthly for six months. If the appropriate care and documentation is completed 100% of the time, monthly monitoring will be stopped and random audits will occur. A sample size of 25% will be completed monthly. If opportunities for improvement are identified through the random audit, a full audit will resume. If after 6 months of random audits, 100% compliance continues, auditing will stop. Pressure areas will always be an area of concern and will continue to remain on the agenda monthly for the Quality Assurance Committee to review and discuss.	

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	his (LPN #2's) own judgement for assessing and treatment of wounds. Interview of LPN #2 on 06/20/12 at 1:55 p.m. indicated Pressure I meant the area was a stage 1 area. Review of "Pressure Ulcers in the Long Term Care Setting- copyright 2008" a stage 1 ulcer was identified as, "intact skin with non blanchable redness of a localized area." The documentation identified a stage 2 pressure ulcer as being "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed, without slough*. May also present as an intact or open/ruptured serum-filled blister." A nurse's note dated 05/01/12 at 7:45 p.m. indicated, "Assessed pressure 1 area to coccyx area now pink. Cont A&D ointment q [every] shift....Depends on staff for care...Will cont to observe wkly [weekly]." This nurse's note was signed by LPN #2. A "Weekly Pressure Ulcer Healing Record," dated 05/01/12 indicated, Resident #34 had a pink closed area - "continue to monitor wkly [weekly]." A nurse's note dated 05/14/12 at 5:00 a.m. indicated, "Observed Res [Resident #34]			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN COMMUNITY HOME	111 W CHURCH AVE SEYMOUR, IN 47274

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	to have an open area 2 cm x cm (sic) on coccyx area. Area is pale/pink, no odor, no drainage...MD notified. [Name of wound nurse] (LPN #2) notified. Requested order from MD to have WCN(wound care nurse) (LPN #2) eval & treat." A nurse's note dated 05/14/12 at 9:10 p.m. indicated, "N.O. [new order] received to have wound care nurse evaluate et treat area on coccyx. Wound care nurse notified of area. A nurse's note dated 05/15/12 at 9:00 p.m. indicated, "Assessed area on coccyx. Stg [Stage] 1. Area cont to be pink. Cont A&D ointment q shift & prn [as needed]....Incont of B & B...." This nurse's note was signed by LPN #2. A "Weekly Pressure Ulcer Healing Record," dated 05/15/12 indicated Resident #34 had a pink stage 1 area on her coccyx. A nurse's note dated 05/22/12 at 9:00 p.m. indicated, "Assessed pressure 1 area to coccyx. Area is chronic condition & will monitor weekly for area to be continue improvement (sic). Area is opened this week. Measuring 0.4 x 0.4 x (less than sign) 0.1. Continue A&D ointment q shift....This nurse's note was signed by			

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	LPN #2. A weekly pressure ulcer healing record dated 05/22/12 indicated Resident #34 had a 0.4 cm x 0.4 cm stage 1 pressure area on her coccyx.... "Area opened up. Cont [Continue] A&D ointment (preventative ointment frequently used for diaper rash)." A nurse's note, dated 05/24/12 at 8:30 p.m., indicated a physician's response to Resident #34's blood sugars. The nurse's note lacked documentation supporting the physician was notified of Resident #34 having a new open area. A Weekly Pressure Ulcer Healing Record, dated 05/31/12, indicated, "Area open - wound 1 x 1 cm [centimeter] 0.2 cm deep, stage 2...covered wound with moist collagen & Allevyn dsy [dressing]." A nurse's note dated 05/31/12 at 10:30 p.m. indicated, "When checking Res (Resident #34's) coccyx, found that area has re-opened approx [approximately] 1.0 x 1.0 cm, round in appearance, pink/dusky in color. 0 [No] drainage. Approx 0.2 cm deep. Cleansed area c N.S. [normal saline]. Applied moistened collagen (wound treatment) to area, then applied Allevyn (wound treatment) Thin			

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	to area. Left msg in care track for wound care nurse (LPN #2)." During interview, on 6/21/12 at 8:30 A.M., with LPN #3, she indicated she had applied the collagen and dressing because the area was open and had left a note in caretracker for the wound nurse. She indicated she thought the area needed a dressing as it was open. LPN #3 indicated she had not notified a physician. The next entry on the Weekly Pressure Ulcer Healing Record, dated 06/05/12, indicated the area was "improved" and A&D ointment was used. Wound measurements for this date were 0.8 cm x 0.7 cm, a stage 2 pressure ulcer. A Weekly Pressure Ulcer Healing Record, dated 06/12/12 indicated Resident #34's coccyx area wound measured 0.2 x 0.6 cm. and A&D ointment was the treatment at this time, a stage 2 pressure ulcer. A nurses notes entry, dated 6/14/12 8 p.m., indicated " assessed pressure I area to coccyx. Measures .2 by .2 by less than .1. A & D continues every shift...routinely dependant on staff for all care..." A physician's telephone order, dated 06/18/12, indicated, "Pressure Area to			

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	coccyx: Cleanse c NS [Normal Saline] apply Collagen piece, foam & cover q day & prn x 7 days & re-eval." The facility lacked evidence of the physician having been notified of the area opening from a stage 1 pressure area on 5/22, to a stage 2 pressure area on 5/31/12, and remaining a stage 2 pressure area, until 6/18/12. Interview of LPN #2 on 06/19/12 at 2:00 p.m. indicated he was the wound nurse and the physician usually wanted LPN #2 to assess the wound and do what he wanted to do (for treating wounds)." On 06/20/12 at 1:35 p.m. LPN #2 was observed to measure the area on Resident #34's coccyx. The area measured 1.5 length x 1.1 width x 1.5 depth. The area was observed to have yellow slough in center with pink surrounding the slough. LPN #2 indicated the area was a stage III area. The clinical record was reviewed on 6/21/12 at 9:00 A.M. and documentation was lacking of the facility having made the physician aware of the area worsening to a stage 3 pressure ulcer. Documentation on A&D ointment was provided by the DON on 06/19/12 at 3:35			

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	p.m. The documentation indicated A&D ointment was a skin protectant which helped to treat and prevent diaper rash and help to seal out wetness. The documentation indicated the A&D ointment should be used with each diaper change, especially at bedtime when exposure to wet diapers may be prolonged. Interview of LPN #2 (Wound Nurse) on 06/19/12 at 2:00 p.m. indicated the ointment used for the "House Barrier Cream" was A&D ointment." A policy statement titled "Pressure Ulcer Treatment" was provided by the DON on 06/19/12 at 2:40 p.m. The policy was not dated. The policy statement indicated, "Policy Statement: Treatment of a pressure ulcer will vary depending on the orders of the attending physician. Since there is marked diversity in the treatment of pressure ulcers, no one specific treatment is identified....When a pressure ulcer is identified, a licensed nurse initiates a preventative plan of care, notifies the physician regarding treatment and documents notification in the clinical record, initiates the weekly pressure ulcer report, and initiates daily documentation of the wound....If the ulcer is not healing, reassess the treatment plan. If necessary, the plan and strategies should be revised			

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	if progress is not noted within 2-4 weeks...." 3.1-40(a)(2)			